to prevent MACE-M varied greatly (range, 10-106; Fig). Paradoxically, a normal CST for high-risk EVAR or open AAA patients was associated with higher MACE-M.

Conclusions: Among VQI institutions, there is extreme variation in utilization of preoperative CST before vascular surgery. Routine CST does not uniformly improve prediction of MACE-M beyond risk stratification alone and may be falsely reassuring. In an era of cost containment, foregoing an unnecessary CST has the potential to add value to health care delivery by reducing costs and improving resource utilization.

Author Disclosures: A. Abou-Zamzam: Nothing to disclose; **B. S. Brooke**: Nothing to disclose; **D. M. Ihnat**: Nothing to disclose; **L. S. Kraiss**: Nothing to disclose; **M. Trinidad**: Nothing to disclose.

RR12.

The Impact of a Hospitalist Comanagement Service on Vascular Surgery Inpatient Outcomes

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Objectives: Vascular surgery patients have increased medical comorbidities that amplify the complexity of care. We aim to assess the impact of a hospitalist comanagement service (HCS) on inpatient vascular surgery outcomes.

Methods: A cohort of 1059 patients was divided into two groups for comparison: 515 between January 2012 and December 2012, before the implementation of a HCS, and 544 between January 2013 and October 2013, after the initiation of a HCS. Nine vascular surgeons and 10 hospitalists participated in the HCS. End points measured were in-hospital mortality (IHM), length-of-stay (LOS), 30-day readmission rates (RAR), 0 to 10 pain scale scores, patient satisfaction measured using Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reports, inpatient adult safety assessments using the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality (IQI) reports, and nurse perceptions assessed by survey.

Results: The IHM rate decreased from 1.75% to 0.37% after the implementation of the HCS ($P = .016$), with a decrease in the observed:expected (O:E) ratio from 0.89 to 0.22. Mean LOS was unchanged, 5.1 days vs 5.5 days (P = NS). The 30-day RAR decreased from 23.1% to 21.7% (P = NS). Patients reporting no pain during hospitalization increased from 72.8% before the HCS to 77.8% after ($P = .04$). Reports of moderate pain decreased from 14% to 9.6% ($P = .016$). Mild and severe pain scores, patient satisfaction measured by HCAHPS, and adult safety measured by AHRQ were similar between the two groups. Nurses perceived an overall improvement in patient care after starting the HCS.

Conclusions: The HCS has resulted in a significant decrease in in-hospital mortality rates and improved pain scores. Subjectively, nurses perceived improved patient care. Continued observation will be necessary to assess the long-term effect of the HCS on quality metrics.

Author Disclosures: A. Briones: Nothing to disclose; **A. Dunn**: Nothing to disclose; **P. L. Faries**: Nothing to disclose; **E. Gabriel**: Nothing to disclose; **R. Malik**: Nothing to disclose; **M. L. Marin**: Nothing to disclose; **R. O. Tadros**: Nothing to disclose; **A. G. Vouyouka**: Nothing to disclose.

RR13.

Impact of Acute Postoperative Limb Ischemia Following Cardiac and Thoracic Aortic Surgery

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Objectives: Acute limb ischemia (ALI) is a rare complication of cardiac and thoracic aortic surgery. Its impact on patient morbidity and mortality is poorly understood. The goals of this study were to identify risk factors for ALI and measure its impact on clinical outcomes.

Methods: Prospectively collected data (2002-2012) from The Society for Thoracic Surgery database on all cardiac and thoracic aortic surgery patients at a tertiary care-academic medical center were included. Univariate regression was used to test for the association of ALI with candidate risk factors. Multivariate regression and Cox proportional hazards modeling were used to test for the independence of effects. Primary outcomes were perioperative death, 30-day readmission, and long-term survival.

Results: ALI developed postoperatively in 231 of 14,560 (1.6%) patients. Independent preprocedural risk factors for ALI were female sex (odds ratio (OR), 1.6; $P < .01$), current/former tobacco use (OR, 2.1 and 1.5; $P < .01$), and history of peripheral arterial disease (OR, 2.3; $P < .01$). Independent procedural and postprocedural risk factors for ALI were emergent/urgent operation (OR, 2.9 and 2.1; $P < .01$), intra-aortic balloon pump (OR, 4.3; $P < .01$) or extracorporeal membrane oxygenation (OR, 4.6; $P < .01$), thoracic aortic procedure (OR, 1.45; $P = .04$), subsequent cardiac procedures (OR, 2.1; $P < .01$), and postoperative iliac/femoral dissection (OR, 22; $P < .01$). Seventy-two patients (31%) with ALI had additional operations, most commonly thrombectomy and major amputation. No independent association between ALI and perioperative mortality or readmission ≤30 days was detected. Despite this, ALI was associated with decreased long-term survival (hazard ratio, 1.5; $P < .01$), with a median follow-up of 27 months (interquartile interval, 5.3-63 months).

Conclusions: Although we did not appreciate an independent association between ALI and short-term morbidity and mortality, this complication heralded increased mortality over the long-term. Therefore, strategies to improve care for this high-risk population of patients should be the focus of future investigation.

Author Disclosures: J. E. Bavaria: Nothing to disclose; **S. M. Damrauer**: Nothing to disclose; **N. Desai**: Nothing to disclose; **R. M. Fairman**: Nothing to disclose; **B. Jackson**: Nothing to disclose; **G. J. Wang**: Nothing to disclose; **X. Wang**: Nothing to disclose; **E. Woo**: Nothing to disclose.